



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HORIZON EVALUATORS INC
11058 REGENCY GREEN DRIVE
CYPRESS TX 77429-4757

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0241-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 5/11/11 I received a call from Cheryl T with approval notice for Chronic Pain Management...As per the Texas Department of Insurance statute 413.014(e) 'if a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service', this is also stated in rule 133.240."

Amount in Dispute: \$10,080.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that the provider is not entitled to reimbursement. The provider did not establish that it obtained pre-authorization for chronic pain management specifically for a shoulder sprain/strain only nor did it submit documentation showing that chronic pain management was provided to treat specifically a shoulder sprain/strain only that occurred one year before treatment."

Response Submitted by: Flahive, Ogden & Latson, PO Box 301339, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2011 May 12, 2011 June 6, 2011 June 7, 2011 June 8, 2011 June 9, 2011 June 10, 2011	Chronic Pain Management – CPT Code 97799-CP (8 hours X 7 dates = 56hours)	\$10,080.00	\$5600.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. Texas Labor Code 413.014, effective September 1, 2005, prohibits the insurance carrier from raising the issue of medical necessity on preauthorized treatment.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 13, 2011

- 216-Based on findings of a review organization.
- W9-Unnecessary medical treatment based on peer review.

Explanation of benefits dated August 12, 2011

- 214-Workers compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
- 216-Based on findings of a review organization.
- W9-Unnecessary medical treatment based on peer review.
- Services denied . Please contact the SRS Claims Examiner regarding these charges

Explanation of benefits dated September 7, 2011

- The procedure on this date was previously reviewed.
- 18-Duplicate claim/service.
- 214-Workers compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
- 216-Based on findings of a review organization.
- W9-Unnecessary medical treatment based on peer review.
- Services denied . Please contact the SRS Claims Examiner regarding these charges.

Explanation of benefits dated September 9, 2011

- The procedure on this date was previously reviewed.
- 18-Duplicate claim/service.

Issues

1. Does a compensability issue exist?
2. Are the disputed services preauthorized?
3. Does a medical necessity issue exist?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the chronic pain management program based upon reason code "214-Workers compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment."

The May 19, 2010 compensable injury was a right shoulder sprain/strain.

Review of the submitted medical bills finds that the disputed chronic pain management was treatment for the following diagnosis code: "840.9-sprains and strains of shoulder and upper arm NOS". Therefore, the Division finds that the requestor has supported that the disputed treatment was for the compensable injury.

2. The requestor states in the position summary that "On 5/11/11 I received a call from Cheryl T with approval notice for Chronic Pain Management."

On May 11, 2011 the requestor obtained preauthorization approval for 10 units of code 97799.

The Division finds that the disputed services were preauthorized.

3. The respondent also denied the chronic pain management program based upon "W9-Unnecessary medical treatment based on peer review."

Texas Labor Code 413.014(e) states "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service."

Therefore, the respondent's denial of reimbursement for the disputed treatment based upon reason code "W9" is not supported.

4. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP for 56 hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is \$100.00 per hour ($\$125.00 \times 80\%$) $\times 56$ hours = \$5600.00. The respondent paid \$0.00. The difference between the MAR and amount paid is \$5600.00. This amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$5600.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$5600.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

5/17/2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.